

# TAKE CHARGE

## Family Planning Waiver Renewal

Renewal Month: \_\_\_\_\_

CSLD/WKR: \_\_\_\_\_

Return this form or call us by:

**Use this form** to renew your coverage for family planning waiver services. If you **do not** renew, your coverage will end. You may renew by mail, fax, phone, or in person.

### How to Renew:

**By mail:** Fill out and sign this form. Return the form and needed proofs (see page 3) in the envelope provided. If you need extra space on any question, use a separate sheet of paper.

**By fax:** Fill out and sign this form. Fax it and needed proofs (see page 3) to the fax number on the notice that came with this form or fax it to 1-877-523-2987.

**By phone:** Call the worker who sent you this form or call (toll-free) 1-888-342-6207 Monday through Friday 8:00 A.M. to 4:00 P.M. Press 1 for English and then 0 for an operator who can transfer you to your worker. You must speak to your worker to renew by phone.

**In person:** Visit your closest Medicaid office or Application Center. For the office closest to you, call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

What language do you speak best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (list) \_\_\_\_\_  
What language do you write best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (list) \_\_\_\_\_

### 1. Tell us about you – The woman who gets family planning waiver services.

Your Name \_\_\_\_\_  
*First Middle Initial Maiden Last*

Home Address \_\_\_\_\_  
*Street Address Apartment/Lot Number*  
\_\_\_\_\_  
*City State Zip Code*

Mailing Address (if different) \_\_\_\_\_  
*P.O. Box or Street Address Apartment/Lot Number*  
\_\_\_\_\_  
*City State Zip Code*

Your Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Parish Where You Live \_\_\_\_\_

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

E-mail Address \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Daytime Phone (\_\_\_\_\_) \_\_\_\_\_

Best Day/Time to Call Monday through Friday Between 8 a.m. and 4:30 p.m. \_\_\_\_\_

### 2. Tell Us On the Next Page About the Other People Living With You – List your husband first (if married) and then all children under age 18. If no one lives with you, go to Question 3.

*If there are more than 4 people, use a separate sheet of paper. Social Security numbers must be given for spouse, children, and anyone who gets Medicaid.*

**If you have questions or need help filling out this form, call our office at 1-888-342-6207.  
If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.  
These calls are free.**

Name (first, middle initial, last) \_\_\_\_\_

Date of Birth (month, day, year) \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to You: ☐ Husband ☐ Child ☐ Step-Child ☐ Grandchild ☐ Other \_\_\_\_\_

Name (first, middle initial, last) \_\_\_\_\_

Date of Birth (month, day, year) \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to You: ☐ Child ☐ Step-Child ☐ Grandchild ☐ Other \_\_\_\_\_

Name (first, middle initial, last) \_\_\_\_\_

Date of Birth (month, day, year) \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to You: ☐ Child ☐ Step-Child ☐ Grandchild ☐ Other \_\_\_\_\_

Name (first, middle initial, last) \_\_\_\_\_

Date of Birth (month, day, year) \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to You: ☐ Child ☐ Step-Child ☐ Grandchild ☐ Other \_\_\_\_\_

### 3. Health Insurance

Do you have Medicare? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes – Fill Out Below ☐ No – Go to Question 4

Policyholder's Name \_\_\_\_\_ Coverage Start Date \_\_\_\_\_

Insurance Company Name and Phone Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

It covers: ☐ Hospital ☐ Doctor ☐ Medicine ☐ Dental ☐ Ambulance ☐ Pregnancy ☐ Family Planning

### 4. Pregnancy

Are you pregnant? ☐ Yes ☐ No Expected Due Date \_\_\_\_\_

Are you expecting more than one baby? ☐ Yes ☐ No

### 5. Income from Working

Does anyone work (you, your husband, or children under age 18)? ☐ Yes – Fill Out Below ☐ No – Go to Question 6

Tell us about **each** full-time job, part-time job, or business.

Who works?	Employer/Business Name and Phone Number	Self Employed	How much? (gross, not take home pay)	How often paid?
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

## 6. Other Income - Not from Working

Do you or does anyone in your home get any money that is not from a job like:

- Social Security • SSI • Unemployment • Retirement • Worker's Compensation • Child Support • Alimony
- Money From Friends and Relatives • Anything Else

☐ Yes – Tell Us About It Below ☐ No – Go to Question 7

Who gets it?	What is it?	How much? (gross, not take home)	How often?
			<input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly
			<input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly
			<input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly

## 7. Child Care and Adult Care

Do you or does your husband pay for child care or care for an adult **with a disability** in order to work, go to school, or get training? ☐ Yes – Fill Out Below ☐ No – Go to Question 8

Name of Child(ren) or Adult Who Gets Care \_\_\_\_\_

Who pays for the care? \_\_\_\_\_ How much is paid each month? \_\_\_\_\_

Is help received with paying it from anyone or another program? ☐ Yes - How much? \_\_\_\_\_ ☐ No

Name of Daycare Center or Caregiver \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

## 8. Child Support and Alimony

Does anyone pay court-ordered child support or alimony to someone not living in your home? ☐ Yes ☐ No

If **yes**, to whom? \_\_\_\_\_ Person in Your Home Who Pays It \_\_\_\_\_

How much and how often? \_\_\_\_\_

### Send Us These Things

Pay stubs from last month showing gross pay (before taxes) or a letter from the employer. If self-employed, send copies of last year's tax return and all schedule attachments – **for you, your husband, and children under 18.**

Proof of gross income (before taxes) from Veteran's Benefits, worker's comp, alimony, and any other income that is not from working. Proof could be award letters and 1099 tax statements from last year's tax return - **for you, your husband, and children under 18.**

Statement from friends or relatives who give money to you, your husband, or children

Proof of child care payments from the day care center. Proof of payments for adult care from the caregiver.

Court order and proof of alimony or child support that you or your husband **PAYS** to someone **outside your home.** **If it is paid through Louisiana Support Enforcement Services (SES), you **do not** have to send proof – let us know.**

# YOUR RIGHTS AND RESPONSIBILITIES

## WHAT THE MEDICAID/TAKE CHARGE PROGRAM HAS THE RIGHT TO EXPECT OF YOU

**CITIZENSHIP AND IMMIGRATION STATUS:** You state that you and/or the person(s) renewing coverage for Medicaid/Take Charge are U.S. citizens or they are in this country legally.

**REPORTING THE TRUTH:** You state that the information you give on this renewal form is true and correct. You understand if you purposely give information that is not true OR if you purposely do not tell information that you are supposed to, you may get health benefits you should not get. If that happens, by law you can be punished for fraud. Also, you may have to pay money back to the Medicaid/TAKE CHARGE Program for the bills it paid by mistake.

**VERIFICATION OF INFORMATION:** You understand that the information you give about yourself and/or the person(s) applying will be checked. You agree to help do this and to let the Medicaid/TAKE CHARGE Program get information it needs from government agencies, employers, medical providers, and others.

**SOCIAL SECURITY NUMBERS:** You understand Social Security numbers will only be used to get information from other government agencies to make a decision about eligibility for you and/or the person(s) applying for Medicaid/TAKE CHARGE.

**PAYMENT OF MEDICAL CARE BY A THIRD PARTY:** You understand by accepting Medicaid/family planning waiver services, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that the Medicaid/TAKE CHARGE Program has paid for you and/or the person(s) applying.

**REPORTING CHANGES:** You agree to tell the Medicaid/TAKE CHARGE Program within 10 days of these changes: 1) if anyone getting family planning waiver services moves out of state; 2) if there are any changes in your mailing or home address; 3) if anyone getting family planning gets health insurance or Medicare; and 4) if anyone getting family planning becomes pregnant.

**CHILD SUPPORT ENFORCEMENT:** You understand that the Medicaid/TAKE CHARGE Program will only send case information to Child Support Enforcement for medical support if you ask them to.

## WHAT YOU HAVE THE RIGHT TO EXPECT FROM THE MEDICAID/TAKE CHARGE PROGRAM

**RIGHT TO A FAIR HEARING:** You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

**NO DISCRIMINATION:** You understand that Medicaid/TAKE CHARGE Program cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818



**YOU MUST SIGN BELOW**



**Sign Your Name Here:** \_\_\_\_\_ **Date** \_\_\_\_\_

*If someone from Medicaid or a Medicaid Application Center helped you fill out this form, they will sign below.*

\_\_\_\_\_ **Date** \_\_\_\_\_

**Please return this renewal form right away. We will give you more time to get the documents of proofs if you need it. If you need the address or fax number to your local Medicaid office, call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404. These calls are free.**

Department of Health and Hospitals  
Voter Registration Declaration (Optional)

If you fill it out, your answers will not affect the benefits you get from the  
*Louisiana Department of Health and Hospitals.*

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

- If you checked "Yes," please complete the attached form called the "Louisiana Mail Voter Registration Application." You may mail your completed Voter Registration Application to your local Registrar of Voters listed on the application or mail it to the Department of Health and Hospitals.
- **IF YOU DO NOT CHECK EITHER BOX YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. **You may call us toll-free at 1-888-342-6207.** The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you choose to register to vote at this time, the information about the location where you completed the application to register will remain confidential and will only be used for voter registration purposes. If you choose not to register to vote, that information will also be kept confidential.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

Louisiana Secretary of State  
Commissioner of Elections  
P.O. Box 94125  
Baton Rouge, LA 70804-9125  
Phone: (toll-free) 1-800-883-2805

\_\_\_\_\_  
Print Your Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Sign Your Name

\_\_\_\_\_  
Today's Date

**ACADIA**

Courthouse #115  
Crowley, LA 70526-4363  
(337) 788-8841  
**ALLEN**  
P. O. Box 150  
Oberlin, LA 70655-0150  
(337) 639-4966

**ASCENSION**  
828 S. Irma Blvd. #205  
Gonzales, LA 70737-3631  
(225) 621-5780

**ASSUMPTION**  
P. O. Box 578  
Napoleonville, LA 70390-0578  
(985) 369-7347

**AVOYELLES**  
312 N. Main St. #E  
Marksville, LA 71351-2409  
(318) 253-7129

**BEAUREGARD**  
P. O. Box 952  
DeRidder, LA 70634-0952  
(337) 463-7955

**BIENVILLE**  
P. O. Box 697  
Arcadia, LA 71001-0697  
(318) 263-7407

**BOSSIER**  
P. O. Box 635  
Benton, LA 71006-0635  
(318) 965-2301

**CADDO**  
P.O. Box 1253  
Shreveport, LA 71153-1253  
(318)226-6891

**CALCASIEU**  
1000 Ryan St. #7  
Lake Charles, LA 70601-5250  
(337)437-3572

**CALDWELL**  
P. O. Box 1107  
Columbia, LA 71418-1107  
(318) 649-7364

**CAMERON**

P. O. Box 1  
Cameron, LA 70631-0001  
(337) 775-5493  
**CATAHOULA**  
P. O. Box 215  
Harrisonburg, LA 71340-0215  
(318) 744-5745

**CLAIBORNE**  
507 W. Main Suite 1  
Homer, LA 71040-3914  
(318) 927-3332

**CONCORDIA**  
4001 Carter St. #4  
Vidalia, LA 71373-3021  
(318) 3367770

**DESOTO**  
105 Franklin St.  
Mansfield, LA 71052-2046  
(318) 872-1149

**E. BATON ROUGE**  
222 St. Louis #201  
Baton Rouge, LA 70802-5860  
(225) 389-3940

**E. CARROLL**  
P. O. Box 708  
Lake Providence, LA 71254-0708  
(318) 559-2015

**E. FELICIANA**  
P. O. Box 488  
Clinton, LA 70722-0488  
(225) 683-3105

**EVANGELINE**  
200 Court St. Ste. 102  
Ville Platte, LA 70586-4463  
(337) 363-5538

**FRANKLIN**  
Courthouse  
6560 Main St.  
Winnsboro, LA 71295-2750  
(318) 4354489

**GRANT**  
Courthouse  
200 Main St.  
Colfax, LA 71417-1828  
(318) 627-9938

**IBERIA**

300 S. Iberia St. #110  
New Iberia, LA 70560-4543  
(337) 369-4407  
**IBERVILLE**  
P. O. Box 554  
Plaquemine, LA 70765-0554  
(225) 687-5201

**JACKSON**  
500 E. Court St. #102  
Jonesboro, LA 71251-3400  
(318) 259-2486

**JEFFERSON**  
P. O. Box 10494  
Jefferson, LA 70181-0494  
(504) 736-6191

**JEFFERSON DAVIS**  
302 N. Cutting Ave.  
Jennings, LA 7054-65361  
(337) 824-0834

**LAFAYETTE**  
1010 Lafayette #313  
Lafayette, LA 70501-6885  
(337) 291-7140

**LAFOURCHE**  
307 W. 4th St. #101  
Thibodaux, LA 70301-3105  
(985) 447-3256

**LASALLE**  
P. O. Box 2439  
Jena, LA 71342-2439  
(318) 992-2254

**LINCOLN**  
100 W. Texas Ave.  
Ruston, LA 71270-4463  
(318) 251-5110

**LIVINGSTON**  
P. O. Box 968  
Livingston, LA 707540968  
(225) 686-3054

**MADISON**  
100 N. Cedar St.  
Tallulah, LA 71282-3892  
(318) 574-2193

**MOREHOUSE**

129 N. Franklin  
Bastrop, LA 71220-3815  
(318) 281-1434  
**NATCHITOCHES**  
P. O. Box 677  
Natchitoches, LA 71458-0677  
(318) 357-2211

**ORLEANS**  
1300 Perdido #1W23  
New Orleans, LA 70112-2127  
(504) 658-8300

**OUACHITA**  
122 St John St #114  
Monroe, LA 71201-7342  
(318) 3271436

**PLAQUEMINES**  
P. O. Box 989  
Port Sulphur, LA 70083-0989  
(504) 564-6957

**POINTE COUPEE**  
211 E. Main St.  
New Roads, LA 70760-3661  
(225) 638-5537

**RAPIDES**  
701 Murray St.  
Alexandria, LA 71301-8099  
(318) 473-6770

**RED RIVER**  
P. O. Box 432  
Coushatta, LA 71019-0432  
(318) 932-5027

**RICHLAND**  
P. O. Box 368  
Rayville, LA 71269-0368  
(318) 728-3582

**SABINE**  
400 Capitol St. #107  
Many, LA 71449-3099  
(318) 256-3697

**ST. BERNARD**  
8201 W. Judge Perez Rm. 104  
Chalmette, LA 70043-1696  
(504) 278-4231

**ST. CHARLES**

P. O. Box 315  
Hahnville, LA 70057-0315  
(985) 783-2731  
**ST. HELENA**  
P. O. Box 543  
Greensburg, LA 70441-0543  
(225) 222-4440

**ST. JAMES**  
P. O. Box 179  
Convent, LA 70723-0179  
(225) 562-2330

**ST. JOHN**  
1801 W. Airline Hwy  
LaPlace, LA 70068-3344  
(985) 652-9797

**ST. LANDRY**  
P. O. Box 818  
Opelousas, LA 70571-0818  
(337) 948-0572

**ST. MARTIN**  
Courthouse  
415 S. Martin St.  
St. Martinville, LA 70582-4549  
(337) 394-2204

**ST. MARY**  
500 Main St. #301  
Franklin, LA 70538-6144  
(337) 828-4100

**ST. TAMMANY**  
701 N. Columbia St.  
Covington, LA 70433-2709  
(985) 809-5500

**TANGIPAHOA**  
P. O. Box 895  
Amite, LA 70422-0895  
(985) 748-3215

**TENSAS**  
P. O. Box 183  
St. Joseph, LA 71366-0183  
(318) 766-3931

**TERREBONNE**  
P. O. Box 9189  
Houma, LA 70361-9189  
(985) 873-6533

**UNION**

P. O. Box 235  
Farmerville, LA 71241-0235  
(318) 368-8660  
**VERMILION**  
100 N. State St. #120  
Abbeville, LA 70510  
(337) 898-4324

**VERNON**  
P. O. Box 626  
Leesville, LA 71496-0626  
(337) 239-3690

**WASHINGTON**  
Courthouse Bldg.  
900 Washington St.  
Franklinton, LA 70438  
(985) 839-7850

**WEBSTER**  
P. O. Box 674  
Minden, LA 71058-0674  
(318) 377-9272

**W. BATON ROUGE**  
P. O. Box 31  
Port Allen, LA 70767-0031  
(225) 336-2421

**W. CARROLL**  
P. O. Box 71  
Oak Grove, LA 71263-0071  
(318) 428-2381

**W. FELICIANA**  
P. O. Box 2490  
St. Francisville, LA 70775-2490  
(225) 635-6161

**WINN**  
Courthouse Room 105  
Winnfield, LA 71483-3238  
(318) 628-6133

**OFFICIAL USE ONLY**

**Address Change**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name Change**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Party Change**

\_\_\_\_\_  
\_\_\_\_\_

**Remarks**

\_\_\_\_\_

**Circle One: PA MV RG SDA SS**

**Received by:\_\_\_\_\_**

**PLACE IN AN ENVELOPE AND MAIL TO YOUR REGISTRAR OF VOTERS**

USE THIS FORM TO: 1) register to vote 2) change your address 3) request a name change 4) change party affiliation

TO REGISTER TO VOTE AND BE ELIGIBLE TO VOTE YOU MUST: 1) be a United States citizen 2) be at least 17 years old to register but must be 18 years old to vote 3) not be under an order of imprisonment for conviction of a felony 4) not be under a judgment of full interdiction or limited interdiction where your right to vote has been suspended 5) reside in the state and parish in which you seek to register and vote.

INSTRUCTIONS FOR COMPLETING THIS FORM: All information except your signature should be printed clearly in ink, preferably black, or typed. Fill in all boxes that apply to you.

**Box 1:** Indicate whether you are a citizen of the United States of America. Indicate whether you will be 18 years of age on or before election day.

**Box 2:** Provide full name. Do not use initials for middle or maiden name.

**Box 3:** 'Residence Address' means the address where you live and are registering to vote. If you claim a homestead exemption, you must list the address of that residence. Do not use a post office box for your 'Residence Address'. If you use a rural route and box number, draw a map in the space labeled 'Give Location.' Write in the names of the crossroads (streets) nearest to where you live. Draw an X to show where you live. Use a dot to show any schools, churches, stores or landmarks near where you live and write the name of the landmark. Check the box provided if mail is not delivered to your residence address by the post office. Complete 'Mailing Address' only if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

**Box 4:** Provide your age.

**Boxes 6 & 14:** You must provide your Louisiana driver's license number, if issued. If not issued, you must provide at least the last four digits of your social security number, if issued. The full social security number may be provided on a voluntary basis. If neither a social security number nor a Louisiana driver's license number has been issued, and this form is submitted by mail, and you are registering to vote for the first time, in order to avoid additional identification requirements for first time voters, attach either a) a copy of a current and valid photo identification or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

**Boxes 8, 12 & 13:** The items 'race/ethnic origin', 'home phone' and 'daytime phone' are not required but are helpful.

**Box 9:** If you do not complete this item, your party affiliation will be listed as 'none', unless you are presently registered with a party affiliation and no change is being made today. If you are not registering with a political party, circle 'none'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

**Box 18:** If you are using this form to request a change of name, you must print the name to be changed here.

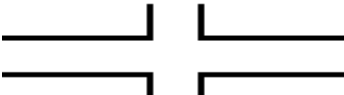
**Box 19:** Date and sign the card with your signature or mark.

If returned by mail, place in an envelope and mail to the appropriate registrar of voters at the address found on the reverse side of this card. If you have not been issued a social security number or Louisiana driver's license number, you must mail the required documentation with your application. Your application or envelope must be postmarked 30 days prior to the first election in which you seek to vote based on the residence listed on this application.

**NOTE:** 1. If you decline to register to vote, this fact will remain confidential and will be used only for voter registration purposes. If you register to vote, the office where your application was submitted will remain confidential and will be used only for voter registration purposes. 2. Your social security number will also remain confidential and is intended to be used for voter registration purposes only.

**QUESTIONS?** Call your Parish Registrar of Voters OR call the Department of State at 1-800-883-2805 or (225) 922-0900.

COMPLETE AND CHECK ALL APPLICABLE BOXES AND TEAR ALONG PERFORATED LINE BEFORE MAILING.

LOUISIANA MAIL VOTER REGISTRATION APPLICATION FORM #04				OFFICIAL USE ONLY COMP REG # _____ Reg Type _____ Wd/ Dist _____ Pct _____ In _____ Out _____			
1 Are you a citizen of the United States of America? YES <input type="checkbox"/> NO <input type="checkbox"/> Will you be 18 years of age on or before election day YES <input type="checkbox"/> NO <input type="checkbox"/> If you checked no in response to either of these questions, DO NOT COMPLETE THIS FORM.							
2 NAME OF APPLICANT (PLEASE PRINT NAME) LAST _____ First _____ FULL MIDDLE OR MAIDEN _____						GIVE LOCATION 	
3 RESIDENCE ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY) HOUSE OR APT. NO. & STREET _____ CITY OR TOWN _____ STATE _____ ZIP _____							
IF NO mail delivery to residential address, check here: ( ) _____ MAILING ADDRESS IF DIFFERENT _____							
4 AGE _____	5 DATE OF BIRTH MONTH _____ DAY _____ YEAR _____		6 * SOCIAL SECURITY # (CIRCLE ONE) NO _____ YES # _____		7 SEX (CIRCLE ONE) MALE _____ FEMALE _____		8 ** RACE/ ETHNIC ORIGIN (CIRCLE ONE) WHITE _____ BLACK _____ ASIAN _____ HISPANIC _____ AMER. INDIAN _____ OTHER: _____
9 PARTY AFFILIATION (CIRCLE ONE) DEM GRN LBT RFM REP NONE OTHER (SPECIFY) _____			10 APPLICANTS'S PLACE OF BIRTH CITY OR TOWN _____ PARISH OR COUNTY _____ STATE _____ COUNTRY _____			11 MOTHERS MAIDEN NAME _____	
12 ** HOME PHONE _____			13 ** DAYTIME PHONE _____		14 LA DRIVERS LICENSE / I.D. # (CIRCLE ONE) NO _____ YES # _____		15 Will you require assistance at the polls? (CIRCLE ONE) NO YES IF YES, GIVE REASON _____
16 LAST RESIDENCE ADDRESS ADDRESS _____			17 PLACE OF REGISTRATION PARISH OR COUNTY _____ STATE _____		18 FOMER REGISTERED NAME, IF APPLICABLE _____		
AFFIRMATION : I do hereby solemnly swear or affirm that I am a United States citizen, that I am at least 17 years old, that I am not currently under an order of imprisonment for conviction of a felony, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than \$1,000 (\$2,500 for subsequent offense) or imprisonment for not more than 1 year.							
19 SIGN YOUR NAME IN BOX AT RIGHT DATE: _____ / _____ / _____							
20 IF YOU ARE UNABLE TO SIGN YOUR NAME, TWO WITNESSES TO YOUR MARK MUST SIGN HERE WITNESS SIGNATURE _____ WITNESS SIGNATURE _____							
* Last 4 digits of the social security number required if no LA driver's license issued; social security number is intended to be used for voter registration purposes only Full # Optional ** OPTIONAL LR-1M (REV. 1/11, 7/11) R.S. 18:104 FORM #04							